

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/20/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/01/2016
NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaints IN00202545 and IN00202994.</p> <p>This visit was in conjunction with the PSR to the PSR for a Recertification and State Licensure Survey completed on April 7, 2016, and the Investigation of Complaints IN00189411 and IN00190705 completed on April 7, 2016.</p> <p>This visit was in conjunction with the PSR to the Investigation of Complaint IN00197967 completed on April 18, 2016.</p> <p>This visit was in conjunction with the PSR to the Investigation of Complaints IN00198223 and IN00200002 completed on May 25, 2016.</p> <p>Complaint IN00202545-Substantiated with no deficiencies.</p> <p>Complaint IN00202994-Substantiated with no deficiencies.</p> <p>Survey date: June 30 and July 1, 2016</p> <p>Facility number: 000070 Provider number: 155149 AIM number: 100266190</p> <p>Census bed type: SNF: 5 SNF/NF: 64 Total: 69</p> <p>Census by payor source: Medicare: 6 Medicaid: 57</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	<p>Continued From page 1</p> <p>Other: 6 Total: 69</p> <p>Sample: 5</p> <p>Harcourt Terrace Nursing and Rehabilitation was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the to the Investigation of Complaints IN00202545 and IN00202994.</p> <p>Quality Review was completed by 21662 on July 8, 2016.</p>	F 000			